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19. Travel. Travel expenses incurred for facility business that is related to patient care are allowable costs. Travel must be documented as to the person traveling, dates of the trip, destination, purpose of the trip, expense description, and the cost. Travel incurred by employees not related to the owner for "in-town travel" (travel within the town of the facility) does not need to be itemized if the expenditure is less than $50.00.

20. Utilities. This includes electricity, natural gas, fuel oil, water, waste water, garbage collection, hazardous waste collection, telephone and communications and cable television charges.

21. Medicaid Assessment. The nursing facility, ICF-MR and PRTF assessments referred to in Section 43-13-145, (1), (2), and (3), Mississippi Code of 1972, as amended, will be considered allowable costs on the cost report filed by each long-term care facility, in accordance with the CMS Provider Reimbursement Manual, Part 1, Section 2122.1.

B. Non-Allowable Costs

Certain expenses are considered non-allowable for Medicaid purposes because they are not normally incurred in providing patient care. These non-allowable costs include, but are not limited to, the following types of expenses.

1. Advertising Expense - Non-Allowable. Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Policies adopted by the Division of Medicaid will be used as a basis for changes in audits of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing audits.

D. Roster Reports and Bed Hold Reports.

Roster Reports are available to all facilities electronically. Roster Reports should be checked by the facilities to determine if all assessments completed by the facility have been entered into the Division of Medicaid case mix database and if all discharge dates are reflected on the report. Missing assessments and discharge dates should be submitted electronically ~~before the due date listed on the report~~ prior to the close of the quarter. If the ~~due~~ quarter close date is on a weekend or a State of Mississippi holiday or a federal holiday, the data should be submitted on or before the first business day following such weekend or holiday.

Final quarterly Roster Reports will be available electronically to facilities. Even though it is too late to submit data to affect a closed quarter, any missing assessments or discharge dates should be submitted electronically in order to be reflected on the next quarter's Roster Report.

schedule required by the Division of Medicaid.

3-3 Resident Classification System

The Division of Medicaid will use the M³PI to classify nursing home residents so a facility case mix average may be computed. This classification system utilizes specific items from the MDS to assign residents to categories which reflect the resident's functional status as well as resource utilization to meet resident care needs. The M³PI contains thirty-four (34) total groups and is based on a descending hierarchical order ranging from most resource intense to least resource intense. (The graphic depiction of the classification hierarchy included at the end of this section provides a visual representation of this narrative).

For nursing facility rates established for dates of service on or after January 1, 1999, the Division shall utilize the most current version ~~5.12~~ of the Mississippi M³PI. The ~~Version 5.12 of the~~ Mississippi M³PI uses the same grouper methodology as the CMS ~~version 5.12 of the~~ RUGS-III 34 group classification system, ~~with the 34 group logic~~with the exception of special treatments and procedures which are utilized only if provided after admission/re-entry to the facility.

The ADL Index is an extremely important component of all classifications, providing the final determination of group (Note: the exception is in the major category of Extensive Services and Special Care where a resident must meet an ADL Index requirement before being classified into ~~Extensive Care~~those categories). An ADL Index is calculated for all assessments.

Depression Groups

The major category of Clinically Complex has first level splits which indicate whether or not a resident meets specific indicators of depression. In order to be classified in one of the depression groups, the following criteria must be present based on the MDS:

~~**Persistent sad or anxious mood** and **three or more** of the mood and behavior patterns specified in the version 5.12 of the Mississippi M³PI.~~ As specified in the Mississippi M3PI, the presence and frequency of symptoms of depression are determined by a standardized severity score greater than or equal to 9.5. The Total Severity Score is derived from responses to items contained in the **PHQ-9**© Resident interview or the **PHQ-9-OV**© Staff Assessment of Mood.

Nursing Rehabilitation Groups

Three of the major categories have as their first level split a determination of whether or not a resident is receiving nursing rehabilitation activities. The major categories for which this split applies are Impaired Cognition, Behavior Problems, and Reduced Physical Functioning.

In order to be computed as receiving Nursing Rehabilitation, a resident must receive two (2) or more types of nursing rehabilitation at least six (6) days a week a minimum of fifteen (15) minutes a day. Nursing Rehabilitation includes the techniques/practices specified in the ~~version 5.12 of the~~ Mississippi M^3PI.

In a hierarchical classification system, assessments are sorted from those having the highest acuity/resource utilization to those with the least acuity/resource utilization. Once the criteria for placement in one of the seven major categories is met, the M³PI calculation program looks at the assessment on the basis of the ADL Index and whether or not it meets the requirements for Depression or Nursing Rehabilitation. Once that has been determined, the final classification is made.

An additional classification is included to allow placement of assessments for ~~whom~~which calculation in the M³PI is not possible due to errors. This classification (BC1) is given the same weight as the lowest classification.

The classification ~~of residents~~ will be calculated electronically ~~performed by computer~~ at the Division of Medicaid using the MDS assessment~~s~~ and the M³PI calculation program. Submission requirements are addressed in section 3-2(A).

X 80%) to equal a minimum of eighty percent (80%) occupancy. Reserved bed days will be counted as an occupied bed for this computation. Facilities having an occupancy rate of less than eighty percent (80%) should complete Form 14 when submitting their cost report.

3-6 State Owned NF's

NF's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs, subject to the Medicare upper limit. A state owned NF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned NF's file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period, subject to the Medicare upper limit.

3-7 Adjustments to the Rate for Changes in Law or Regulation

Adjustments may be made to the rate as necessary to comply with changes in state or federal law or regulation.

3-8 Upper Payment Limit

NF's may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each facility, the amount that Medicare would have paid for the previous year will be calculated and compared to what payments were actually made by Medicaid during that same time period. The calculation will be made as follows: MDS data is run for each facility to group total patient days into one of the ~~forty-four~~ RUGs. The total population is used, case mix adjusted, and the therapy portion is removed. An estimated amount that Medicare would have paid on average by facility is calculated by multiplying each adjusted RUG rate by the number of days for that RUG. The sum is then divided by the total days for the estimated average per diem by facility that Medicare would have paid. From this amount, the Medicaid average per diem for the time period is subtracted to determine the UPL balance as a per diem. The per diem is then multiplied by the Medicaid days for the period to calculate the available UPL balance amount for each facility. This calculation may then be used to make payment for the current year to nursing facilities eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to 100 percent of the difference between Medicaid payments and what Medicare would have paid may be paid to State government-owned or operated facilities, non-state government-owned or operated facilities, and privately owned and operated facilities, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

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